Adult Day Health Care Services (age 18 and over)

Definition: Services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Authorization of services will be based on the participant's need for the service as identified and documented in his/her Support Plan. Meals provided as part of this service shall not constitute a full nutritional regime (3 meals per day). Physical, occupational and speech therapies indicated in the participant's Support Plan are not furnished as component parts of this service.

The unit of service is one "participant day," which is a minimum of 5 hours of a day, exclusive of transportation. The unit of service will be a minimum of 4 hours when the participant has a scheduled medical appointment requiring him or her to leave early or arrive late.

Please see Scope of Services for Adult Day Health Care Services.

Providers: Centers/agencies contracted with SCDHHS to provide Adult Day Health Care Services under the ID/RD Waiver. These centers/agencies are listed on the Adult Day Health Provider Listing or you may contact your supervisor if you have questions about a center's/agency's enrollment status.

Arranging for and Authorizing Services: Adult Day Health Care services are only appropriate for those ID/RD Waiver participants who are at least 18 years of age.

Once it is determined that Adult Day Health Care services are needed, the Service Coordinator must document the need for the services in the participant's Support Plan and offer the participant or his/her family choice of providers. The Service Coordinator must document this offering of choice.

Once the amount and frequency has been determined and the family has selected a provider, the chosen provider should be contacted to determine space/service availability. Also, at this point, budget information can be entered into the Waiver Tracking System. Once the budget is approved, the Service Coordinator may authorize the service. Services must be authorized using the Authorization for Adult Day Health Care Services (MR/RD Form A-23).

The Authorization for Adult Day Health Care Services (MR/RD Form A-23) will remain in effect until a new form changing the authorization is provided to the Adult Day Health Care center/agency or until services are terminated.

Prior to starting the service, the Adult Day Health Care center/agency must obtain the Community Long Term Care Adult Day Health Care Form (DHHS Form 122 DC) from the physician.

Monitoring Services: The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Adult Day Health Care Services:

- During the first month of service, monitoring must be conducted while the service is being provided.
- Services must be monitored at least once during the second month of service.
- Services must be monitored at least at the time of every 6 month Plan review thereafter.
- The monitoring schedule must start over any time there is a change of provider.

- Monitoring must be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Except for the initial monitoring, this service may be monitored during a contact with the participant/family or service provider. It may also occur during review of written documentation at the Adult Day Care Center or during an on-site visit.
- In order to ensure a participant's health and safety are adequately monitored, it may be necessary to make more frequent contacts with the participant/family and/or the ADHC provider. All contacts must be fully documented in the participant's waiver record.

Some questions to consider during monitoring include:

- Is the participant satisfied with the Adult Day Health Care Center?
- Is the ADHC Center clean (sanitary)?
- Is the ADHC Center in good repair?
- How often does the participant attend?
- Are there any health/safety issues?
- How often does the ADHC Center staff have contact with family?
- Are there any behavior problems?
- What types of recreational activities does the person participate in?
- What types of recreational activities does the ADHC Center offer?
- Does the participant feel comfortable interacting with staff?
- What are the opportunities for choice given to the participant?
- What type of care is the participant receiving?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER

AUTHORIZATION FOR ADULT DAY HEALTH CARE SERVICES

☐ ***BILL TO S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES*** *(include Prior Authorization # below)*
☐ ***BILL TO FINANCIAL MANAGER:*** _____
_____
_____

TO: _____

You are hereby authorized to provide **Adult Day Health Care Services (X6987)** ***for:***

Participant's Name: _____ **Date of Birth:** _____

Address: _____
_____
_____

Phone Number: _____ **Medicaid #:** _____ **Social Security #:** _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # _____

Start Date: _____

Authorized Total: __ Units per week (One unit = one 5-hour day)

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____
_____

Phone # _____

_____ _____
Signature of Person Authorizing Services Date